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JOINT COMMITTEE ON FINANCE

MEMORANDUM

To: Members
Joint Committee on Finance

From: Senator Mark Miller
Representative Mark Pocan

Date: December 2, 2010

Re: Department of Family Medicine of the UW School of Medicine and Public Health Report to JFC

Attached is a report on the Wisconsin Rural Physician Residency Assistance Program from the Department of Family Medicine of the UW School of Medicine and Public Health, pursuant to s. 36.63 of 2009 Wisconsin Act 190.

This report is being provided for your information only. No action by the Committee is required. Please feel free to contact us if you have any questions.

Attachments

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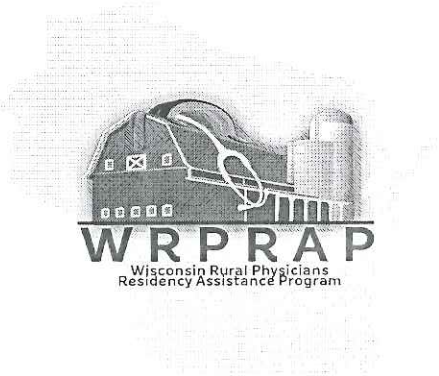

TO: Joint Committee on Finance
Wisconsin State Legislature

FROM: Wisconsin Rural Physician Residency Assistance Program
William Schwab, MD, Director
Department of Family Medicine
University of Wisconsin School of Medicine and Public Health

DATE: November 30, 2010

SUBJECT: Annual Report of the
Wisconsin Rural Physician Residency Assistance Program

Executive Summary

Section 36.63 of 2009 Wisconsin Act 190 created the Wisconsin Rural Physician Residency Assistance Program (WRPRAP) and designated the Department of Family Medicine (DFM) of the University of Wisconsin School of Medicine and Public Health (UW SMPH) to administer this initiative as a strategy to address the increasing shortage of rural physicians in Wisconsin. Act 190 provides funding to promote the development of Graduate Medical Education (residency) experiences in communities that have a population under 20,000. In passing this statute, the legislature recognized that resident physicians who train in rural areas have a two- to three-fold increased likelihood of ultimately practicing in a small community. The legislation, which targets new physicians who are receiving specialty training in family medicine, internal medicine, obstetrics-gynecology, pediatrics, psychiatry, and surgery, went into effect on July 1, 2010, after residency program curricula for the 2010-2011 academic year had already been finalized. Consequently, WRPRAP activities to date have been focused on gathering perspectives from rural health advocates, including medical providers, health system representatives, and hospital administrators, as well as from residency educators on how to best structure and implement this program. Progress in the first five months of the WRPRAP has included convening a strategic planning meeting of interested parties, configuring a representative advisory committee, developing criteria for funding pilot activities, disseminating information about the role of residency education in increasing the rural health work force, and developing the necessary infrastructure within the Department of Family Medicine to effectively accomplish the goals of the program. Interest in this initiative is high. It is anticipated that with sustained financial support from the legislature, there will be a progressive expansion of residency education in rural communities throughout the state.

Background

The Wisconsin Council on Medical Education & Workforce (WCMEW) has documented a significant shortage of physicians practicing in rural Wisconsin. 83% of Wisconsin counties (60/72) are designated as totally or partially underserved. 77% of these underserved counties are rural. It is projected that this deficit will increase substantially over the next twenty years unless there is targeted action to address it. This has profound implications for the health of Wisconsin's citizens as well as for the economic viability of the state.

Research has indicated that there are several factors that make physicians more likely to practice in small communities. They include a personal history of living in a rural area and the availability of adequate professional opportunities for spouses/partners. High quality medical resources, excellent partners, competitive financial compensation, and adequate clinical support personnel are also important elements in the successful recruitment of physicians to rural areas. Studies have shown that an additional major factor is medical school and residency experiences in rural areas, which has been found to a result in a two- to three-fold increased likelihood of ultimately practicing in a small community.

Rural health advocates in Wisconsin have identified a number of proactive strategies to respond to the challenge of maintaining a viable rural health infrastructure in every part of the state. They have particularly promoted evidence-based approaches in medical education that are likely to increase the physician workforce. One of these innovative programs is the Wisconsin Academy for Rural Medicine (WARM), a comprehensive rural medical education program established in 2007 within the University of Wisconsin School of Medicine and Public Health, which enrolls 25 students per year.

Residency education is the next step in medical training after the completion of medical school. However, the availability of rural Graduate Medical Education (residency) experiences in Wisconsin is minimal. Wisconsin currently has only one Rural Training Track (RTT) residency program, the Baraboo program sponsored by the UW Department of Family Medicine, with capacity for two residents per year. A decade ago, there were seven RTTs, all in Family Medicine, but this was not sustainable because of inadequate student interest. And while a number of Family Medicine programs in the state have relatively brief rotations of varying durations sited in small rural hospitals and clinics, this is not consistent and there are a number of logistical and financial barriers to developing and maintaining these valuable experiences. In addition, such experiences in other specialties are much less frequent.

The Wisconsin Rural Physician Residency Assistance Program (WRPRAP) was established by the state legislature on July 1, 2010, through the enactment of Act 190. The Department of Family Medicine (DFM) of the University of Wisconsin School of Medicine and Public Health (UW SMPH) was designated in the legislation to administer this program. $750,000 was allocated in 2010-2011 for the planning and implementation of rural GME experiences in family medicine, internal medicine, obstetrics-gynecology, pediatrics, psychiatry, and surgery. It is necessary for funding to be maintained in future years in order to stimulate and sustain innovative residency curricula in rural areas throughout the state in each of the targeted specialties in partnership with clinicians, hospitals, and health systems.

Required Reporting

Section 36.63 (4) of Act 190 enumerates specific information that is to be reported to the Joint Committee on Finance by December 1:

36.63 (4) (a)

The number of physician residency positions that existed in the 2009–10 fiscal year, and in each fiscal year beginning after the effective date of this paragraph that included a majority of training experience in a rural area.

2009-2010: ***53*** *-- 5 Baraboo residents + 48 Marshfield residents in the specified specialties*

2010-present: ***54*** *-- 6 Baraboo residents + 48 Marshfield residents in the specified specialties*

36.63 (4) (b)

1. **The number of such physician residency positions funded in whole or in part under this section in the previous fiscal year:**
   None as of 11/30/2010
2. **The eligibility criteria met by each such residency position and the hospital or clinic with which the position is affiliated:**
   Not Applicable
3. **The medical school attended by the physician filling each such residency position:**
   Not Applicable
4. **The year the Accreditation Council for Graduate Medical Education certified the residency position:**
   Not Applicable
5. **The reason the residency position had not been funded:**
   Not Applicable

In interpreting this data, the following should be noted:

- Residency program curricula for 2010-2011, including resident recruitment and scheduling of rotations, had already been completed when this legislation went into effect, so there has been no substantive opportunity to develop new residency experiences this year.
- In the legislation, "rural area" is defined as "a city, town, or village in this state that has a population of less than 20,000 and that is at least 15 miles from a city, town, or village that has a population of at least 20,000 ". Graduate Medical Education that takes place in Marshfield, which has a population of 19,454, meets the criteria for a rural location, so Marshfield

Clinic residents are included in the counts above. The Marshfield Clinic has an important record of providing exceptional medical education in a unique clinical environment in northern Wisconsin. However, most of this education is based at St. Joseph's, an outstanding tertiary care facility that is the second largest hospital in the state, so these experiences are not entirely consonant with the goals of Act 190.

36.63 (3)

Annually by December 1, the department shall submit a plan for increasing the number of physician residency programs that include a majority of training experience in a rural area to the Rural Wisconsin Health Cooperative, the Wisconsin Hospital Association, and the Wisconsin Medical Society. The plan shall include a detailed proposed budget for expending the moneys appropriated to the board under s. 20.285 (1) (qe) and demonstrate that the moneys do not supplant existing funding. The department shall consider comments made by the organizations in formulating its final budget.

Plan has been submitted to the specified organizations

WRPRAP Accomplishments to Date

1. Convened a meeting in Madison on August 20, 2010 attended by more than 40 rural health advocates, hospital administrators, health system representatives, rural physicians, and medical educators. Presentations included a national perspective on the role of GME in promoting future practice in rural areas, a profile of the state's only "Rural Training Track" which is the Baraboo program sponsored by the UW Department of Family Medicine, a description of the rural rotations that have been a required element of the Madison residency program of the UW DFM for nearly 40 years, and a discussion of the financing of GME with emphasis on how this affects the development of GME in rural areas. Participants met in small groups to develop recommendations that have guided the initial direction of the WRPRAP. A summary of this meeting is available at: *http://www.fammed.wisc.edu/rural/08-2010*

2. A web presence has been established at: *http://www.fammed.wisc.edu/wi-rural-physician-program*. The site describes the program, details criteria for funding of projects, and provides links to relevant resources.

3. An Advisory Committee has been configured. It has met twice and will continue to meet every 1-2 months. **(Committee members, Attachment 1)*

4. Preliminary criteria for funding Graduate Medical Education experiences have been developed and are being disseminated with the intent of supporting pilot experiences over the next year. One proposal has been received for the spring of 2011 and a request to support a rural training track position for which there is no external funding available is also anticipated.

5. Criteria for awarding development grants to foster planning for future GME rotations in rural areas and Rural Training Tracks are being finalized.

6. A monograph describing the process for developing a Rural Training Track (RTT) is being planned. An RTT must meet all of the detailed requirements of the Accreditation Council on Graduate Medical Education and must ultimately be approved by that entity. Additionally, application must be made to the federal Centers for Medicare and Medicaid Services (CMS) for funding, which is unfortunately an uncertain proposition. This process typically takes at least three years.

7. Dr. William Schwab was designated by the DFM to direct the WRPRAP ** *(Bio-sketch, attachment 2)*. An administrative assistant for the program has been hired and a position description for a program coordinator is in the approval process within the administration of the UW-Madison academic personnel office. In addition, coordination with the SMPH and UW-Madison has taken place to develop budget processes for this program.

8. Ongoing communication with stakeholders has taken place through electronic updates disseminated by WRPRAP and by partner organizations, the web site, and numerous personal communications.

Future Plans

1. WRPRAP will be expanding its technical assistance capacity to promote GME experiences in rural areas.
    a. Relationships between residency programs and rural health providers will be fostered
    b. New opportunities for pilot experiences will be described
    c. The model of a consortium of Rural Training Track sites with shared administrative support will be explored.

2. Coordination with UW SMPH, particularly the Wisconsin Academy for Rural Medicine program (WARM), and with the Medical College of Wisconsin will be increased to more closely align WRPRAP with rural medical student education experiences in the state.

3. Partnerships among GME programs in Wisconsin to support the recruitment of residents who are interested in rural health will be promoted.

4. Connections with national efforts to increase rural GME opportunities will be strengthened so that initiatives in Wisconsin can benefit from experience in other states.

5. Evaluation strategies to assess the effectiveness of WRPRAP over time will be developed.

6. Another meeting of interested parties from throughout the state will be convened in the spring/early summer.

Conclusion

The Wisconsin Rural Physician Residency Assistance Program is in the important developmental stage of receiving input from interested constituencies to guide its efforts to promote Graduate Medical Education in small communities in Wisconsin as a strategy to ultimately increase the rural physician work force in the state. Both residency programs and rural health providers have communicated that they must have confidence in the stability of continued funding in order to take the next steps in planning rural rotations and pursuing the development of Rural Training Tracks. WRPRAP and the advocates who supported its creation look forward to the continued support of the legislature for this essential long term contribution to the health of the citizens of the state.

* Attachment 1

Advisory Committee

Wisconsin Rural Physician Residency Assistance Program

Mark Belknap, MD (Ashland) Former President, Wisconsin Medical Society

Byron Crouse, MD (Belleville) Associate Dean of Rural and Community Health,
University of Wisconsin School of Medicine and Public Health

Mark Deyo-Svendsen, MD (Menomonie) Family Physician, Red Cedar Medical Center

Valerie Gilchrist, MD (Madison) Chair, Department of Family Medicine,
University of Wisconsin School of Medicine and Public Health

Joseph Kilsdonk, Au.D. (Marshfield) Administrator, Marshfield Clinic Division of Education

Charles Shabino, MD (Wausau) Senior Medical Advisor, Wisconsin Hospital Association

Tim Size (Sauk City) Executive Director, Rural Wisconsin Health Cooperative

William Schwab, MD, Program Director

Clare Loxterkamp, BA, Administrative Assistant

** Attachment 2

William Schwab, M.D.

Director, Wisconsin Rural Physician Residency Assistance Program

Dr William E. Schwab is currently Vice Chair of the Department of Family Medicine (DFM) in the University of Wisconsin School of Medicine and Public Health. A native of Madison, he attended the University of Wisconsin as an undergraduate and graduated from the Case Western Reserve University School of Medicine. He went on to complete his family practice residency at the University of Virginia in Charlottesville. After residency, he worked as a family physician at the New River Family Health Center, a private, non-profit, community-run clinic in the rural coal fields of southern West Virginia.

Dr. Schwab joined the DFM faculty in 1985 and was director of the Madison Family Medicine Residency Program from 2002 until 2008. He is a clinically active family physician at the DFM's Northeast Family Medical Center in Madison where his practice encompasses the full spectrum of family medicine, including hospital and maternity care. He additionally teaches residents at the clinic.

Dr. Schwab is a nationally respected clinician, educator and policy consultant about the care of children with special health care needs and adults with chronic illnesses and disabilities from a family-centered perspective. He is a member of the Board of Directors of the Institute for Patient- and Family-Centered Care in Bethesda, Maryland and, in conjunction with the UW Waisman Center, was principle investigator for the National Medical Home Autism Initiative, funded by the federal Maternal and Child Health Bureau from 2004-2008. He is currently the principle investigator of a grant project from the Centers for Disease Control to enhance developmental screening by family physicians throughout the state of Wisconsin. Dr. Schwab was honored as Family Physician of the Year by the Wisconsin Academy of Family Physicians in 1999 and received the Baldwin Lloyd Teaching Award from Madison Program residents in 1987 and 2008.